Mutual OF OMAHA
MUTUAL BENEFIT HEALTH & ACCIDENT ASS'N., OMAHA, NEBR.

United OF OMAHA
UNITED BENEFIT LIFE INSURANCE COMPANY, OMAHA, NEBR.

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GROUP
EMPLOYEE'S APPLICATION FOR DISABILITY BENEFITS

Employed by _____ Group Policy _____

1. Employee's full NAME.	Age _____ Ins. Cert. No.
2. If claim is for a DEPENDENT.	Name Relationship Age
3. Date injured or beginning of sickness.	, 19 A.M. ☐, P.M. ☐
4. What is the nature of injury or sickness?	
5. If an injury, state when, where and how it occurred.	
6. First date you were unable to work because of this disability.	, 19 A.M. ☐, P.M. ☐
7. On what date did you return to work?	, 19 A.M. ☐, P.M. ☐

Date _____, 19____ Signature _____ (Employee)

Street and No. _____ City or Town _____ State _____

IF CLAIM FOR HOSPITALIZATION AND/OR SURGERY BENEFITS PLEASE ATTACH ITEMIZED BILLS

EMPLOYER'S STATEMENT

1. Employee's full NAME.	Insurance Certificate No. _____ Employee's Insurance Class _____ Date Certificate Effective
2. If claim is for DEPENDENT.	Name Relationship Age
3. Date last worked.	, 19
4. Date returned to work.	, 19
5. Cause & nature of disability (if due to accident state when, where and how it occurred).	
6. Has there been or will there be a claim filed for Workmen's Compensation?	

Employer _____ (Signature of Employer's Representative) (title)

Date _____

MUG 89 8-54

Opposite Side is For Attending Physician's Report

ATTENDING PHYSICIAN'S OR SURGEON'S STATEMENT

1. Patient's NAME.	Age
2. If disability due to ACCIDENTAL BODILY INJURY.	Nature of Injury Brief History
3. If disability due to SICKNESS give FULL DIAGNOSIS.	
4. Date patient injured or beginning of sickness.	, 19
5. Is this a Workman's Compensation case?	
6. What operation, if any, was performed?	Date of Operation , 19 Amount of Charge $
7. Dates patient treated.	At Office At Hospital At Home
8. How long was, or will patient be totally disabled?	From , 19 to , 19

Date , 19

Graduate of
(Medical School)

Signed

Address

Telephone No.